OMB #

SP ID #: _____

SP NAME: _____

INTERVIEWER NAME: _____

INTERVIEWER ID: _____

FACILITY ID #: _____

START TIME: _____ am/pm

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCE ADMINISTRATION

MEDICARE CURRENT BENEFICIARY SURVEY

FACILITY COMPONENT

USE OF HEALTH CARE SERVICES

ROUNDS 18 AND 19

ASSURANCE OF CONFIDENTIALITY

Information contained on this form that would permit identification of any individual or establishment is collected with a guarantee that it will be held in strict confidence by the contractor and HCFA, will be used only for purposes stated in this study, and will not be disclosed or released to anyone other than authorized staff of HCFA without the consent of the individual or the establishment in accordance with the Privacy Act of 1974.

USE OF SERVICES MODULE

CTRL/E OK

US1PRE

This {next} series of questions is about the health care services that {SP} may have received between {REFERENCE START DATE} and {REFERENCE END DATE} while {she/he} resided in {FACILITY/[READ FACILITY/UNITS ABOVE]}. {The questions include any services that {she/he} received outside this facility, as well as care from any providers who saw {her/him} here. The kinds of services I will be asking about include physician care, dental care, mental health services, various kinds of therapies, and care from other kinds of health care providers. I will be asking about the type of provider and the frequency or duration of the services. Please do not include care while {she/he} was an overnight inpatient in an acute care hospital.}

CURRENT TIMELINE

PLACE NAME	START DATE	END DATE	STAY TYPE
{ }	{ }	{ }	{ }
{ }	{ }	{ }	{ }
{ }	{ }	{ }	{ }
ETC.	ETC.	ETC.	ETC.

USE ARROW KEYS. TO EXIT, PRESS ESCAPE.

FACR.US1LONG

US1

Between {REFERENCE START DATE} and {REFERENCE END DATE} while a resident in this {FACILITY/HOME}, did {she/he} see a medical doctor of any kind, outside the {FACILITY/HOME}, excluding mental health therapy provided by a psychiatrist?

YES	1	(US2)
NO	0	(US3)
DK	-8	(US3)
RF	-7	(US3)

USES.OUTMDVST

US2

Between {REFERENCE START DATE} and {REFERENCE END DATE}, how many times did {she/he} see doctors outside this facility?

_____
NUMBER

USES.OUTMDFRQ

US3

Between {REFERENCE START DATE} and {REFERENCE END DATE}, did {she/he} see a medical doctor of any kind, here, in this {FACILITY/HOME}, excluding mental health therapy provided by a psychiatrist?

YES	1	(US5A)
NO	0	(US6PRE)
DK	-8	(US3a)
RF	-7	(US6PRE)

USES.INMDVST

US3A

Please tell me the name and title of someone in {FACILITY/[READ FACILITY/UNITS ABOVE]} who could give me that information.

RECORD RESPONDENT INFORMATION ON PAPER FROG.

Thank you for your time, those are all the questions I have for you. Right now I need to continue with [NAME FROM FROG] to complete these questions.

PRESS ENTER TO CONTINUE.

PERM.USABORT

US5A

Between {REFERENCE START DATE} and {REFERENCE END DATE}, how many times did {she/he} see any doctor here?

( )
NUMBER

USES.ANYMDFRQ

CTRL/E OK

US6PRE

The following questions are about services used both inside and outside this facility. We are only interested in services {SP} received while residing in {FACILITY/[READ FAC/UNITS LISTED ABOVE]}.

PRESS ENTER TO CONTINUE.

US6

Between {REFERENCE START DATE} and {REFERENCE END DATE}, did {she/he} see a dentist, dental surgeon, dental assistant, or any other professional for dental care?

YES	1	(US7)
NO	0	(US8)
DK	-8	(US8)
RF	-7	(US8)

USES.DENTVST

US7

Between {REFERENCE START DATE} and {REFERENCE END DATE}, how many times did {she/he} see a dentist, dental surgeon, dental assistant, or any other professional for dental care?

_____ (US8)
NUMBER

USES.DENTFRQ

US8

Between {REFERENCE START DATE} and {REFERENCE END DATE}, did {she/he} see a psychiatrist or any other mental health care professional either inside or outside this facility?

YES	1	(US9)
NO	0	(US12)
DK	-8	(US12)
RF	-7	(US12)

USES.MENTLVST

US9

What type of mental health specialist did {she/he} see?

SELECT ALL THAT APPLY.

PSYCHIATRIST	(US10)
PSYCHOLOGIST	(US10)
PSYCHIATRIC NURSE	(US10)
PSYCHIATRIC SOCIAL WORKER	(US10)
LICENSED CLINICAL SOCIAL WORKER	(US10)
OTHER (SPECIFY:_____)	(US10)

USE ARROW KEYS. TO SELECT OR DESELECT, PRESS ENTER. TO EXIT, PRESS ESC.

USES.PSYCHIAT .LICSOCW
.PSYCHOLO .PSOTHER
.PSYCNURS .PSYCHOS
.PSYCSOCW

US10

Between {REFERENCE START DATE} and {REFERENCE END DATE}, how many sessions or visits did {she/he} have?

_____ (US11)

USES.PSCIASES .LCSOWSES
.PSCOLSES .PSOTRSES
.PSCNUSES
.PSSOWSES

US11

Were these individual sessions, group sessions, or some of both?

INDIVIDUAL	1
GROUP	2
BOTH	3

USES.PSCIATYP .PSSOWTYP
.PSCOLTYP .LCSOWTYP
.PSCNUTYP .PSOTRTYP

US12

Between {REFERENCE START DATE} and {REFERENCE END DATE}, did {she/he} see a therapist such as a physical therapist, speech therapist, I.V. therapist, occupational therapist, or respiratory therapist?

YES	1	(US13)
NO	0	(US22A)
DK	-8	(US22A)
RF	-7	(US22A)

USES.PHYSTHPY

US13

Please look at this card and tell me about how often each week therapy was provided.

SHOW CARD US1

LESS THAN ONCE A WEEK	1	(US14)
ONCE OR TWICE A WEEK	2	(US14)
3 TO 5 TIMES A WEEK	3	(US14)
MORE THAN 5 TIMES A WEEK	4	(US14)
ONE-TIME EVALUATION	5	(US22A)
DK	-8	(US14)
RF	-7	(US22A)

PRESS F1 FOR INFORMATION ON "ONE-TIME EVALUATION".

USES.PHTPYWKL

US14

Now look at this card. Between {REFERENCE START DATE} and {REFERENCE END DATE}, over how long a period was therapy provided?

SHOW CARD US2

LESS THAN 1 WEEK	1
1 TO 3 WEEKS	2
4 TO 8 WEEKS	3
MORE THAN 8 WEEKS BUT NOT THE WHOLE TIME	4
ABOUT THE WHOLE TIME	5
DK	-8
RF	-7

USES.PHTPYFRQ

US22A

Between {REFERENCE START DATE} and {REFERENCE END DATE} was {SP} seen by a podiatrist (either inside or outside this facility)?

YES	1	
NO	0	

USES.PODRTHPY

US23

Between {REFERENCE START DATE} and {REFERENCE END DATE}, did {she/he} receive educational or habilitational services (either inside or outside this facility)?

PROBE: "Habilitational services" include training in daily living skills, self care, and so on, in a structured program.

YES	1	(US24)
NO	0	(US29)
DK	-8	(US29)
RF	-7	(US29)

USES.EDHBSERV

US24

Were those services educational, habilitational, or both?

EDUCATIONAL	1	(US25)
HABILITATIONAL	2	(US25)
BOTH	3	(US25)
DK	-8	(US25)
RF	-7	(US29)

USES.EDUORHAB

US25

Please look at this card and tell me, between {REFERENCE START DATE} and {REFERENCE END DATE}, over how long a period were these {educational} {habilitational}services provided?

SHOW CARD US4

LESS THAN 1 WEEK	1
1 TO 3 WEEKS	2
4 TO 8 WEEKS	3
MORE THAN 8 WEEKS BUT NOT THE WHOLE TIME	4
ABOUT THE WHOLE TIME	5
DK	-8
RF	-7

USES.EDHABFRQ

BOX US2	If US24 = 3, go to US27; else go to US29.

US27

Between {REFERENCE START DATE} and {REFERENCE END DATE}, over how long a period were these habilitational services provided?

SHOW CARD US4

LESS THAN 1 WEEK	1
1 TO 3 WEEKS	2
4 TO 8 WEEKS	3
MORE THAN 8 WEEKS BUT NOT THE WHOLE TIME	4
ABOUT THE WHOLE TIME	5
DK	-8
RF	-7

USES.HABFRQ

US29

Between {REFERENCE START DATE} and {REFERENCE END DATE}, did {she/he} receive care from <u>any other</u> licensed or certified health care provider (either inside <u>or</u> outside this facility)?

YES	1	(US30)
NO	0	(US31PRE)
DK	-8	(US31PRE)
RF	-7	(US31PRE)

USES.OTHCPROV

US30

What kind of provider was that?

SELECT ALL THAT APPLY.

DIETICIAN
OPHTHALMOLOGIST
OPTOMETRIST
RECREATIONAL THERAPIST
SOCIAL WORKER
NURSE PRACTITIONER
OTHER (SPECIFY: _____)

USES.TYPDIET .TYPSOCWO
.TYPOPHTH .TYPNURSP
.TYPOPTOM .TYPOTHER
.TYPRECRE .TYPERVOS

*** CTRL/E OK***

US31PRE

The next few questions are about any visits {SP} may have made to a hospital emergency room, that is, from {REFERENCE START DATE} through {REFERENCE END DATE}.
Please do not include visits to the emergency room that were immediately followed by inpatient hospital stays.

PRESS ENTER TO CONTINUE.

US32

While {she/he} was in a nursing home, did {she/he} make any visits to a hospital emergency room between {REFERENCE START DATE} and {REFERENCE END DATE}?

YES	1	(US33)
NO	0	(US37)
DK	-8	(US37)
RF	-7	(US37)

USES.ERVISITS

{REF. START DATE} - {REF. END DATE}

US33

On what date did the {first/next} ER visit occur?

MONTH ( ) DAY ( ) YEAR 19( )

EMRG.ERVSTMM .ERVSTDD .ERVSTYY

{REF. START DATE} - {REF. END DATE}

US36

ER VISIT: {DATE FROM US33} 19{YR}

Other than what you have just told me, did {SP} have any other emergency room visits?

YES	1	(US33)
NO	0	(US37)
DK	-8	(US37)
RF	-7	(US37)

EMRG.EROTHVST

US37

{Besides the {health care providers} {and} {emergency room} visits you have already told me about,} {D/d}id {she/he} ever go to the hospital and return on the same day?

YES	1	(US38)
NO	0	(US40)
DK	-8	(US40)
RF	-7	(US40)

USES.RETSMDAY

US38

How many times did this happen between {REFERENCE START DATE} and {REFERENCE END DATE}?

( )
NUMBER

USES.RETSMFRQ

US40

Now I'd like to ask you about any kind of supplies or other types of medical services {SP} received other than the ones I've already mentioned. Please look at this card and tell me what supplies or services {SP} received between {REFERENCE DATE} and {END DATE}.

SHOW CARD US6

SELECT ALL THAT APPLY

DIABETIC EQUIPMENT OR SUPPLIES
EYE GLASSES OR CONTACT LENSES
HEARING AID OR OTHER COMMUNICATION DEVICE
ORTHOPEDIC ITEMS
EQUIPMENT OR SUPPLIES FOR KIDNEY DIALYSIS
OSTOMY SUPPLIES
DISPOSABLE DIAPERS
AMBULANCE SERVICE
PROSTHESIS
OXYGEN
DON'T KNOW
NONE OF THE ABOVE

USES.DIABETEQ .KDIALYEQ .PROSTHEQ
.EYEEQ .OSTOMYEQ .OXYGENEQ
.HEARNGEQ .DIAPEREQ
.ORTHOPEQ .AMBULNEQ

US41

Between {REFERENCE DATE} and {END DATE} did {SP} receive any other medical devices or equipment?

YES	1	
NO	0	(US43)
DK	-8	(US43)
RF	-7	(US43)

USES.OTHEQUIP

US42

Please look at this card and tell me what medical devices or equipment {he/she} received.

SHOW CARD US7

SELECT ALL THAT APPLY

BEDSIDE COMMODE
BED PADS (CLOTH OR DISPOSABLE)
CATHETER AND CATHETER SUPPLIES
CLOTH DIAPERS
FEEDING SUPPLIES (INCLUDE PUMPS, SYRINGES, TUBES)
G TUBE AND SUPPLIES
GERI CHAIR
HOSPITAL BED
IV SUPPLIES
NEBULIZER
SPECIAL MATTRESS, CUSHIONS OR MATTRESS PADS (INCLUDING EGG CRATE, AIR)
SUCTION MACHINE AND SUPPLIES
TED HOSE AND SUPPLIES
WHEELCHAIR/WALKER
SOME OTHER TYPE OF DEVICE OR EQUIPMENT

USES.COMMODE **.FEEDEQPM** **.IVSUPPL** **.TEDHOSE**
.BEDPADS **.GTUBESUP** **.NEBULIZR** **.WHEEWALK**
.CATHETEQ **.GERCHAIR** **.MATTRESS** **.OTHREQPM**
.CLOTDIAP **.HOSPBED** **.SUCTEQPM** **.OTHREQOS**

US43

Please tell me if {SP} received any of the following medical services?

YES = 1, NO = 0

Turning and positioning . . . . . ( )
Tubefeeding . . . . . ( )
Restraints . . . . . ( )
Injections . . . . . ( )

USES.MSTURN **.MSTUBE** **.MSRESTR** **.MSINJECT**

US44

Between {REFERENCE DATE} and {END DATE} did {SP} receive any other medically necessary items or provider services that we haven't talked about already?

YES 1
NO . . . . . 0 (USEND)
DK . . . . . -8 (USEND)
RF . . . . . -7 (USEND)

USES.MEDSOTHR

US45

Please look at this card and tell me what items or services {he/she} received?

SHOW CARD US8

SELECT ALL THAT APPLY

CATHETERIZATION AND IRRIGATION
APPLYING/CHANGING DRESSINGS INCLUDING BANDAIDS
FEEDING (WITH SPOON, SYRINGE, PUMP, OR OTHER DEVICE)
SKIN TREATMENTS FOR PREVENTION,
TREATMENT OF SKIN ULCERS
APPLYING, MONITORING HOT PACKS
IV USE AND CARE
G TUBE USE AND CARE
PACEMAKER CHECK
SUCTIONING
INCONTINENCE
SOME OTHER KIND OF ITEM OR SERVICE

USES.CATHIRRI .SKINSERV .GTUBEUSE .INCNCARE
.CHNGBAND .HOTPACKS .PACEMCHK .OTHRSERV
.FEEDSERV .IVUSE .SUCTSERV .OTHRSEOS

USEND

YOU HAVE COMPLETED THE USE SECTION FOR THIS SP.
PRESS ENTER TO RETURN TO NAVIGATION SCREEN.